[00:00:29.15] **JOHN KIRBY:** Almost from the onset of the coronavirus epidemic in the United States, New York has been described as “the epicenter of the outbreak” and Elmhurst Hospital, in Queens, “the epicenter of the epicenter.”
[00:00:42.14] **MAYOR DIBLASIO:** Obviously, Elmhurst Hospital, in Queens, is, right now, the epicenter within the epicenter.

[redacted]

NY TIMES REPORTER: Elmhurst Hospital is the epicenter of the epicenter.

[redacted]

CBS2 REPORTER: Elmhurst Hospital is the really at the center of this crisis, here in the city, and in the country, with doctors desperately trying to keep up with the growing number of patients as supplies dwindle.

[redacted]

PRESIDENT TRUMP: And you see the black body bags, you say what's in there? It's Elmhurst hospital. Must be supplies. It's not supplies. it's people.
[00:01:10.23] **JOHN:** Also, from the beginning of the crisis, ventilators were described as essential life-saving equipment, initially, in short supply.
[00:01:18.07] **CUOMO:** You pick the 26,000 people who are going to die because you only sent 400 ventilators.

[redacted]

PRESIDENT TRUMP: I knew that every person who needed a ventilator and didn’t get one would die.
[00:01:30.09] **JOHN:** But why does New York, and Elmhurst in particular, appear to have been hit so much harder than other places in the United States? And were ventilators ever the right approach to treating COVID-19, especially once we realized that 60-90% of those vented do not survive? The experience and observations of nurse Erin Olszewski seem to offer some answers to these pressing questions, while simultaneously providing frontline information about a number of other hot button topics, including the disproportionate number of COVID deaths among Americans of color, the distortion surrounding do-not-resuscitate orders, the disregard for personal protective equipment standards, and the clustering of COVID-positive with COVID-negative patients, which she witnessed again and again. And the tremendous amount of nosocomial, or hospital-acquired, infections that resulted.

[redacted]

[00:02:27.05] Perhaps most urgently of all, she speaks of the therapies and protocols employed in her home state that did work. Erin was brought from Florida by a service funded by the Federal Emergency Management Agency. She spent almost a month at Elmhurst; what she saw there compelled her to become a reporter and whistleblower alongside her already extensive nursing duties. She made recordings, posted warnings on social media, and spoke through proxies about the nightmare conditions she witnessed.

[redacted]

[00:03:01.06] Erin was raised in Wisconsin, and enlisted in the army when she was 17, just

before 9/11. She deployed in support of Operation Iraqi Freedom, in 2003. Part of her duties involved overseeing aid disbursement and improvements to hospital facilities. While in country, she received the Army Commendation Medal for Meritorious Service, and was wounded in combat. Erin eventually retired as a sergeant and became a civilian nurse in 2012. A mutual friend who was helping her make hidden camera recordings introduced us to Erin. After working a long shift at the hospital, she agreed to do an impromptu interview in her room at the Marriot Marquis, overlooking Time Square.

[redacted]

[00:03:47.10] We encourage the viewer to leave aside their preconceptions about the nature of what is happening, to hear first-hand from an eyewitness who, at great personal expense, and without political prejudice of any kind, now openly reports what she discovered in the hopes that the information will be put to good use to save lives. She began by telling us one of her most disturbing findings: that people who had repeatedly tested negative for COVID were being described as "COVID confirmed."

[00:04:17.16] **ERIN OLSZEWSKI:** Okay, so if you look close, I'm in my patient's chart. I am pulling up their laboratory results. So, if you look here, you'll see COVID-19 BioReference lab; here are the test results: as you can see, 5/1/2020 at 17:16, "not detected;" the test for a second time, 5/4/2020, at 17:59, "not detected;" so, both of those are negative. Scroll up to the top, this is my patient, they are on a vent, and they are being called "COVID-19 confirmed, droplet and contact and eye protection."

[00:05:02.06] **HIDDEN CAMERA:**

[redacted]

ERIN: So, this person is "droplet and eye COVID-confimed." Positive A, click, "not detected," "no resulting lab available."

[redacted]

NURSE 2: Hi! How are you?

[redacted]

ERIN: Pretty good.

[00:05:24.29] **JOHN:** While Erin was using her hidden camera to document another chart showing a patient with negative test results who, nonetheless, was labeled COVID-confirmed, another travel nurse entered the room. They began to discuss what Erin was seeing.

[00:05:38.24] **HIDDEN CAMERA:**

[redacted]

NURSE 2: This is BioReference?

ERIN: This is, here.

[redacted]

NURSE 2: This is done, here.

[redacted]

ERIN: So "not detected" here, but it's "presumptive." Now, they're all-

[redacted]

NURSE 2: They are "detected." They're saying it's "positive." Not "detected—"

[redacted]

ERIN: But it's not "detected—"

[redacted]

NURSE 2: What does that say? How does that make any--?

[00:05:54.13**] JOHN:** You've said that they were vented immediately upon being brought in? Is that—?

[00:05:58.18] **ERIN:** Yeah, so, the thing is, they're coming in with difficulty breathing and a lot of these patients are really coming in with anxiety because everybody is, they're scared. And when I was back home, I was working in the ED, out in the tents, and most people that were coming through were coming through with symptoms of just anxiety or you know, they're worried and they're breathing fast, and then they get all nervous. So, this is how people are coming in. Now, I'm not saying that some of them don't have COVID. There is, there are people that come in and they really do need help, not to the extent of a vent, but they need help. But these other people, like this person who wasn't COVID, multiple times, you know, and a lot of them are on either Medicaid or Medicare. They're poor. They're from, you know, a lower class. We're at a public hospital. They need the funding. So, take them. They take them.

[00:07:01.08] And they tell them, pretty much, that if they don't get on a vent, then they're probably not going to survive. But the reality is, if they get on that vent, the likelihood of them walking out of the hospital is slim to none.

[00:07:12.28] **JOHN:** And can I ask you, what, like, PEEP are they on, and is that being mandated or specified, what the pressure is on the vent?

[00:07:21.20] **ERIN:** Here's the thing with this: So, you don't have actual doctors that know critical care, ICU doctors, on these floors. There's a dentist and there are residents with these [patients]. So, residents are essentially students, and they have no idea what they're doing. I had to police—actually today, I had to police a resident because he wrote an order for me to run Versed (which is a medicine that you have to be very careful with because it can kill someone), at quadruple the speed of what you should be running it at, at the dose. And had I not known that, then I would have easily killed the patient. And it would have been okay under their "COVID standards." So, everything is kind of a wash. Nobody's held accountable for anything, and these people that are on vents are essentially like, they're—these residents are practicing their skills on them. So, they're practicing central lines, they're practicing invasive procedures that are really unnecessary.

[00:08:29.18**] JOHN:** What is the percentage of Black, Latino, White? What's the racial composition?

[00:08:34.27] **ERIN:** Hispanic and Black, for the majority.

[00:08:38.04] **JOHN:** And what's the age range?

[00:08:39.14] **ERIN:** And Asian.

[00:08:40.12] **JOHN:** And Asian. And what's the age range?

[00:08:43.08] **ERIN:** 20-year-olds all the way up to 70 to 80-year-olds. Very few, I should say, very few 80-year-olds, but...the majority of people, I would say, are in their 40's or 50's.

[00:08:57.01] **JOHN:** Wow. And what percentage of the people that are in there would you say actually have tested positive for COVID?

[00:09:06.04] **ERIN:** Um, half. Probably half.

[00:09:10.17] **JOHN:** But everyone is being treated as though-

[00:09:12.13] **ERIN:** The entire hospital is COVID. So, half the hospital's not COVID, but they're on COVID floors.

[00:09:18.08] **JOHN:** So, let me just ask you about nosocomial infections. So, you're saying they're putting non-COVID, or COVID-rule-out with definite COVID patients?

[00:09:28.02] **ERIN:** Yes.

[00:09:29.04] **HIDDEN CAMERA:**

[redacted]

ERIN: So, I was only wondering, because I was looking at all the patient rooms and this patient is in with a non-COVID. I don't understand why they're doing that.

[redacted]

NURSE 2: I know. There's four patients in a row here [that are] non-COVID. And this is supposed to be the COVID hospice.

[redacted]

ERIN: Yeah.

[redacted]

NURSE 2: 7th floor, they shut it down. They cleaned it.

[redacted]

ERIN: That's why I'm confused.

[redacted]

NURSE 2: And then they're going to have non-COVIDS there.

[redacted]

ERIN: Yeah.

[redacted]

NURSE 2: This is going to be the only COVID, so they shouldn't put any non-COVIDS here.

[redacted]

ERIN: Well, that's what they've been doing-
[00:09:59.08] **ERIN:** They're banking on the fact that they'll get it. Because they're already immunocompromised. So, they're just—and they'll put them in the same room. So, there's double rooms, so you have a COVID with a non-COVID. They don't even care. We have enough rooms where they can be separated now, because it's not as busy as it was, you know, four weeks ago. But they don't care. They're just putting them together. I have that right now happening.
[00:10:23.19] **HIDDEN CAMERA:**

[redacted]

ERIN: And like, the guy over in-

[redacted]

NURSE 2: I have two in 26! I have two in 26 that were two negatives.

[redacted]

ERIN: And they end up positive. Like, the guy over in 29, I had him upstairs because I was in CCU before I—and he came in with a stroke.

[redacted]

NURSE 2: I know. That's what 26-1 was, a stroke.

[redacted]

ERIN: And no COVID, and now he's got COVID, and he's on a vent.

[redacted]

NURSE 2: It's because we gave it to him here.

[redacted]
NURSE 3: I don't know how this ended up being COVID central.
[redacted]
NURSE 4: I know. But she literally came in with a broom and then she left, like five minutes later; my patient had died of COVID, and she didn't mop the floor. She was cleaning, getting prepared for my next patient, and she didn't mop the floor.
[redacted]
NURSE 3: What?
[redacted]
NURSE 4: I was like, that is the least—
[redacted]
NURSE 3: That's the standard.
[redacted]
NURSE 4: I didn't think I had to tell her that.
[00:11:14.29] **ERIN:** People don't know how to properly wear their PPE. Let's go back to Ebola. When Ebola was here, people took that very seriously. You have a nurse in the room, in all of the head to toe PPE—this is Ebola, I'm going to compare it—and you have another nurse that's outside the room handing supplies, you know, the clean nurse and the dirty nurse, right? Going [in and out] and when they're taking their outfit off, the one nurse is unzipping the back, so she can take it out, walking out [backwards], they're not doing that here. We're wearing our scrubs, and then we have maybe a net top, our pants are exposed. They're wearing booties over their shoes, but the booties are going room to room to room and then people will wear them through the hospital.
[00:12:09.07**]** **JOHN:** So, there's massive spread just through the improper use of the PPE—
[00:12:14.06] **ERIN:** I mean, that's.... It's a no-brainer. It looks good. It looks good. It looks like you're super safe, but in reality, it's ridiculous. You're going to go to—you'll go room to room, you'll maybe take that top off, put a new top on, but the rest of you is still exposed.
[00:12:32.18] **HIDDEN CAMERA:**
[redacted]
ERIN: But, I mean, why are they doing this, you know?
[redacted]
NURSE 2: I know. "Suspected," "suspected," and there's like...that, "principal hospital." Does that mean, like a nosocomial? Is that what that means?
[00:12:48.12] **ERIN:** Like, we have, in the United States, and we've had it for a while, a rapid test. It's 45 minutes. Do you have COVID [or] don't you? They're not doing the rapid tests here.
[00:13:02.00] **JOHN:** They're not?
[00:13:03.00] **ERIN:** No.
[00:13:04.11] **JOHN:** Okay. At Elmhurst you've never seen them--
[00:13:07.12] **ERIN:** No. Nope, they don't do it. It's too expensive. They do 5 day. It's like 5-7 day turnaround. In the meantime, they admit them onto COVID units. So, non-COVIDS, the rule-outs, are going to COVID units and waiting for their results. Even though we have a rapid result which is 45 minutes, and they're not doing it. No. Not one.
[00:13:33.15] **JOHN:** But when you say, "it's too expensive," isn't this all getting charged

to the fund anyway? I mean, why not do it? Why not? Are you saying—
[00:13:42.05] **ERIN:** I don't know why. It doesn't make any sense to me. I asked the doctor about it—
[00:13:48.27] **VOICE RECORDING:**
[redacted]
ERIN: How come you guys don't do the rapid tests here?
[redacted]
DOCTOR: Because it's a city place. And it exists, it's just they don't have access to it. It's only a limited supply, so if you have deep pockets, you get it first.
[redacted]
ERIN: Oh, so money.
[redacted]
DOCTOR: Most times it's money, about everything, yes.
[redacted]
ERIN: That's sad.
[redacted]
DOCTOR: It's reality.
[00:14:07.23] **ERIN:** I compare this hospital to a third world country. I've been in a third world country hospital, in Iraq; the Iraq hospital is better than this one, and that says a lot. I've been there. I've been in both hospitals. And we're—this is in the United States, and this hospital is treating low-income, mostly, people. And it almost makes me feel like they think these people are disposable. And they're not. They're people. Everybody...people are not disposable, you know? Especially, especially the ones that are struggling, day in and day out, the hard workers, you know, trying to reach that American dream. They're not given a chance because they're brought to this place where nobody cares.
[00:15:10.11] **JOHN:** And is there an understood financial incentive to diagnose COVID?
[00:15:16.23] **ERIN:** Yeah, of course. So, in the hospital that I'm in right now, it's all COVID, at this point. Every single floor is COVID. And they made it that way, obviously, for a reason, in my opinion. But a person cannot come to the floor unless they have a COVID diagnosis.
[00:15:33.27] **JOHN:** Is the reason—did they not want to cross-contaminate? Is that, would that be the legitimate reason why you would create an all-COVID floor?
[00:15:42.23**] ERIN:** Here's why I will say no to that, is because they're admitting people for "COVID rule-out," so this guy was probably admitted "COVID-rule-out" tested him, they saw that it came back negative. They probably already did something where they needed to now call him "COVID," in the hopes that if they're putting him on a COVID floor, and there's nurses going room to room to room, he will get it and then they'll be, you know, they'll be backed, when he does pass, that he did have COVID.
[00:16:14.06] **JOHN:** Now, I mean, that's quite a charge. What makes you think that they really want them to get COVID? Because it...
[00:16:23.01] **ERIN:** Money. Money. I think it's at least $29,000 per patient. And then you have to think: you're also charging supplies, and more supplies, and more supplies—that’s just, like, a bonus money.
[00:16:36.17] **JOHN:** But, the residents aren't getting that, right? I mean, why-?
[00:16:40.07] **ERIN:** Oh. That's the thing. And I actually had a—I went at it with a lot of residents, already. They're order followers. So, there was a resident (and I have this on tape), I video—I taped it, because it was just so disgusting to me. A 37-year-old (which is my age) was not a DNR. He was

a full-code. His family [had an] in-depth discussed with the doctors, that they want us to do everything we can to save him. He came in talking, very terrified. He was just totally alert, knew what was going on, and they convinced him to be on a vent. Now he's dead. But the doctors said, when I got onto shift, that if he codes, that we are not to resuscitate or try to save him. And we flipped.
[00:17:36.18] **VOICE RECORDING:**
[redacted]
NURSE 2: This is important. I just asked them if we could put a DNR order in. They said, “No, that's up to the attending.”
[redacted]
NURSE 3: Okay. So, we're going to code him?
[redacted]
NURSE 2: That's what I said, and they said, “No, we're not.” I said, “Yes we are—"
[redacted]
ERIN: We are obligated to.
[redacted]
NURSE 2: So, then I said—
[redacted]
NURSE3: We’ve got to say something, though, Like, “It's our license; unfortunately, you guys gotta put in an order.” Or just something—
[redacted]
NURSE 2: That's what I said, I said, "I am obligated.”
[redacted]
NURSE 3: Yeah.
[redacted]
ERIN: What did she say?
[redacted]
NURSE 2: So then, she's like, “The higher-ups said…." I said, “I don't care what they said.”
[redacted]
ERIN: What “higher up?” God? We don't have a god here making decisions.
[redacted]
NURSE 2: I said, "I don't care what they said."
[00:18:04.24] **HIDDEN CAMERA:**
[redacted]
ERIN: So, we're supposed to .... he's not DNR but we're treating it as DNR?
[redacted]
NURSE 5: Basically.
[00:18:14.18] **ERIN:** Basically.

[00:18:14.23] **HIDDEN CAMERA:**

[redacted]

ERIN: Does his family know?

[redacted]

NURSE 5: His family knows the situation. I think they called him, and they told them. They were trying to do a—

[00:18:23.13] **ERIN: "**I think they called them and told them."

[00:18:26.17] **HIDDEN CAMERA:**

[redacted]

ERIN: Okay.

[redacted]

NURSE 5: All day he spent in the 80's, saturated. It was this one, on the forehead. It was this one. And when I changed it, I saw, "shoot it's 90," so they started playing around with the vent settings--

[00:18:39.00] **ERIN:** "Oh, shoot, it's 90," he changed the pulse ox from his head to his finger, and he's like, "Oh, it's 90." He's fine.

[00:18:48.26] **JOHN:** So, what was that?

[00:18:51.22] **ERIN:** So, that was, we were just getting on shift, because we're starting the night shift at 7. And that was the nurse from the day shift saying pretty much we shouldn't code him if he's going to code. And then I turned my glasses on.

[00:19:14.11] **VOICE RECORDER:**

[redacted]

ERIN: Why are we being told not to code him, essentially? That's what he said.

[redacted]

NURSE 2: I mean, because I'm going to tell you right now, if he bottoms out, I'm jumping on his chest. Period. Point blank. It's going to happen.

[redacted]

DOCTOR: Okay.

[redacted]

NURSE 2: Because, until that status is changed in the computer, that's what I'm obligated to do, under my nursing license.

[redacted]

DOCTOR: Right. I mean, um. Uh...

[redacted]

NURSE 2: Because you guys aren't going to back me up or protect me.

[redacted]

DOCTOR: Well, Elmhurst does have a policy, given, like, a COVID policy, given the scarcity of dialysis and blood.

[redacted]

NURSE 2: It can be a Chem Code, it can be whatever.

[redacted]

DOCTOR: But, it's not, There's not a....it's a different...normally the standard is whatever the family says, like, we just do. So, they will say, "Code him for 5 years," you just do that.

[redacted]

NURSE 2: Right.

[redacted]

[00:19:52.26] **DOCTOR:** It's a little bit different now, because of the new policy in place, that Dr. [BLEEPED OUT] put in place, which is that you don't need full family consent. Like you can just tell someone that it's medically futile and that we're not willing to just pour blood and resources into someone that would be impossible to get back.

[redacted]

NURSE 2: Right.

[redacted]

DOCTOR: But I, look, it's brutal. he's 37. I mean, It's brutal.

[redacted]

[00:20:26.27] **ERIN:** Well, they tried.

[redacted]

NURSE 2: And I said, "Well, our higher-ups agreed, and our attendings agreed that this is futile care at this point. He's not going to make it." And I said, "Well, he doesn't have an Epi Drip going. He doesn't have anything to sustain going." And I said, "Who decided this? Can you put a comfort care order in?" No, we can't do that. "Can you put a DNR order in?" "No, we can't do that." I said, "So what's our plan?"

[redacted]

NURSE 3: Do we modify plans?

[redacted]

NURSE 2: "Well," she goes, "well he's dying." And I'm like, "I understand that, but there needs to be an order indicating that either I'm not doing compressions, or I'm not doing compressions."

[redacted]

NURSE 3: Right.

[redacted]

ERIN: Well, I can say that we can all be in agreement that we will do it. I will definitely.

[redacted]

NURSE 3: Yeah.

[redacted]

NURSE 2: Because I'm going to jump on him.

[redacted]

ERIN: So will I. I will right with you. I don't care. That's what we're here for. I'm not playing these stupid games.

[redacted]

NURSE 2: Until they change his status, that he is a DNR, and they can do it through physician consent, if they've talked to the family, but until they change it, and I see it, he's a full code to me.

[00:21:14.21] **ERIN:** We know when someone is...we're close. We'll pull the code card up and be ready, you know. We're ready. I had the Epi ready. That's one of the first things we do. And she wouldn't let me give it. So, this was that woman. And then entire time, and this was over his body, his alive body, and we're arguing, and she's laughing, she was smirking. And how this man died was the nurses arguing with the doctors over him, as he was dying. And she's smirking the entire time. I was so—it was probably one of the worst experiences in my entire life. But all I can think about is that at least he knows that we were fighting for him when he died, you know? But this was my conversation after what happened. And the guy I told you about earlier that had pulled his tube out, he was up at that point, like, he was on the same floor. He had pulled his—he was the one that they wanted to sedate. So, at that point he was doing better, where he could walk. This doctor had put a diaper on him and told him to poop in his pants. So, after the code, I went to go check on him, and he's—he goes, "I have poop in my pants," I'm like, "Why do you have poop in your pants?" And he said that [it was] because the doctor told him that he has to do that. And I just lost it. It was her.

[00:23:04.00] **VOICE RECORDING:**

[redacted]

ERIN: This is wrong. It is straight up—it is wrong. And I have been—I am 37 years old, I have been in a hospital since I've been 16. Military hospitals as well.

[redacted]

DOCTOR: What aspect of this is wrong to you? I agree that there were parts of this that were wrong too, so—

[redacted]

ERIN: Calling a patient a DNR when there's no order for it. And telling us, straight up telling us, "You're not doing anything." That's wrong. If that was my brother, or my father, or anybody, I would be furious. And I guarantee you, if I called his family right now and told them what happened, they would be furious too.

[00:23:42.15] **ERIN:** I flipped. We were all crying. There were a lot of nurses that were—that know that this is wrong, but they're afraid to say anything publicly.

[00:23:51.07] **VOICE RECORDING:**

[redacted]

NURSE 2: She said, when I was talking to her, she said, "We don't always, we're not always given the orders. It comes from the top down." And I was thinking, "That's my exact problem with everything. Where's it coming from? What's the purpose? Are you guys really trying to kill everybody, like everybody thinks?"

[00:24:09.13] **ERIN:** Within our unit, we—it was a big fight—and ultimately, the kid died with us over his body arguing about this.

[00:24:20.07] **VOICE RECORDING:**

[redacted]

ERIN: And the doctors—he’s like, "The doctor will just write it up, that we, you know, coded." I'm sorry, I'm not doing that [BEEP].

[00:24:32.04] **ERIN:** There’s a doctor that came upstairs, that I had worked with

prior. He was working in the ED, heard about what happened. He came into the room with me, and told me that what I did was good, and that.... So, there are good doctors in here, you know. I guess the word travelled after this.
[00:24:49.12] **KIRBY:** You mentioned earlier that this is a common occurrence, where people come in able to speak and they just have low oxygen levels and they're put on a vent. So, what's going on there?
[00:25:05.20] **ERIN:** I don't know. I honestly, I have no idea how...they're assuming everybody is just the same. There is no individuality anymore. These residents, I think a lot of them are just stone cold, you know? There's no emotion and they don't view people as people anymore. And it's really sad. We came, I came, a little bit later, you know, after the big rush, but there were still a lot of people coming in and a lot of us were just in shock, within the first couple of days, you could see exactly what was going on.
[00:25:40.20] **VOICE RECORDING:**
[redacted]
NURSE 2: My bigger problem with this whole scenario is when they intubate people that don't need it.
[redacted]
ERIN: Yeah.
[redacted]
NURSE 2: And it looks very clear to me that they're just pushing it.
[00:25:51.25] **ERIN:** You almost feel like you are literally living in the twilight zone. And you feel like you're the only sane one in a bunch of insane people. And it's scary because these are the people that others are trusting to take care of them, and they're really doing the opposite. I'm to the point where I'm afraid that I'm going to start thinking that this is normal. I don't want to ever get to that point, because they think that. Like, the people I work with, that are local nurses and doctors, don't see anything wrong with this.
[00:26:28.13] **JOHN:** Really? I mean, they don't—was it just kind of a hard past few months? Or-?
[00:26:36.18] **ERIN:** This has been like this, and from what I hear, like, I mean, there are good nurses that work there too. I have made good friends with a lot of the nurses that do work there. There's good people. But they're outnumbered.
[00:26:55.11] **JOHN:** So, what happens? People come in, like this 37-year-old, and what was he complaining of or what was going on?
[00:27:01.17] **ERIN:** Respiratory distress. He didn't have COVID either. He did not have COVID.
[00:27:07.19] **JOHN:** And how do we know that?
[00:27:08.17] **ERIN:** I took care of him. I have the same type of results from his chart as I do my other patient.
[00:27:15.07] **VOICE RECORDING:**
[redacted]
ERIN: It was, like, the day before intubation. He was fine on the rebreather.
[redacted]
NURSE 2: And then they intubated, and then he got a Pneumo, and then they put in a chest tube, and then it turned to—
[redacted]
ERIN: And now he's 37-years-old and dead.

[00:27:29.03] **ERIN:** That's what I'm seeing. Like, all these negative tests, and they're putting them on these vents, hopeful that they'll get it. They're being put on these COVID floors. It's murder. it, straight up, is—it is setting these people up for failure based on money.
[00:27:50.10] **JOHN:** Medicaid is—who pays out? Or who is paying this bonus of $29,000?
[00:27:55.07] **ERIN:** I believe it's Medicaid. Medicare. It's government money, but I don't know exactly where it's coming from. I know that it is—but I know the orders are coming from "The above." Someone above. and everybody says that it's someone higher up. I'm like, "Good. Call them." Like, during that DNR, when they're telling us, or the full code, when they're telling us not to do CPR, I'm like, "Alright. Call your higher ups, then. Let's talk." And they wouldn't. Because they're all scared. Everybody's scared. And everybody's scared to stick up for themselves. And I've called a lot of doctors unethical to their face, and they deserve it.
[00:28:41.07] **VOICE RECORDING:**
[redacted]
ERIN: I am a nurse. I'm an advocate for my patients. And to—
[redacted]
DOCTOR: On the flip side of it—but I totally agree. We shouldn't be not coding if there's a DNR –
[redacted]
ERIN: But, no, no, no. Just wait. You were laughing, and you thought it was funny. You were, like, smirking. You were being really rude to all of us. And I thought that was really dis—
[redacted]
DOCTOR: Not in that instance. I'm not being rude in that instance.
[redacted]
ERIN: It was really—yeah, you were. It was very disrespectful. And I don't think that you're going to be a very good doctor.
[redacted]
DOCTOR: Okay. I understand. Thank you.
[redacted]
ERIN: You're welcome. I hope you learn something from this.
[00:29:09.13] **JOHN:** Was this the dentist? Or was this—or are these are residents you're talking to?
[00:29:13.02] **ERIN:** This one was a fellow. She was a CCU fellow. Cardiac. She's a cardiac fellow.
[00:29:21.05] **JOHN:** What killed him? Was being—did the vent kill him?
[00:29:24.20] **ERIN:** Yeah. Oh yes. They're so sedated. He had probably 8 or 9 drips. It's all sedation. It's all sedation and paralytics. So, you are asleep. It is, essentially, like you're under, you know, you're in surgery, you know, when they put you under like that, for a good month straight. There’s no way you can recover from something like that. You're braindead if you do.
[00:29:50.28] **JOHN:** So, can you list some of the drugs that they are put on, on the drips?
[00:29:56.17] **ERIN:** Yeah. There's Propofol, Fentanyl, Nimbex, Versed…gosh. Hang on, I have a list. I made a list from—this is one of my patients. One of my patients was on this, just one patient: So, Nimbex, 100 mg; Precedex, 400mg; Fentanyl, 2500 mcg; Heparin, 25,000 units; Versed 50mg; Levophed 16,000 mio, 50 mg; Propofol, 10 mg; Vasopressin 100 units. This is one person. And all these drips are running at the same time into them.
[00:30:41.03] **JOHN:** So, in the case of this 37-year-old, he comes in complaining of

some respiratory distress. Did he have low blood oxygen?
[00:30:49.15] **ERIN:** Totally healthy guy. And he was satting (that's the oxygen saturations) in like 88, 89.
[00:30:58.25] **JOHN:** So, a little low.
[00:30:59.16] **ERIN:** I mean, yeah. But, people do that. You and I probably do that. We're not monitoring our oxygen all day long.
[00:31:08.07] **JOHN:** But he felt shortness of breath, so he came in?
[00:31:11.05] **ERIN:** Yes.
[00:31:12.03] **JOHN:** And what was the next step? What would have happened next?
[00:31:16.26] **ERIN:** He went to a step-down unit. Among other—
[00:31:20.13] **JOHN:** What does that mean? Sorry.
[00:31:22.01] **ERIN:** It's just a unit where people aren't quite on the vent yet. And I say, "On the vent yet," because that's—I should call it "step-up unit" to the vent. But—
[00:31:32.16] **JOHN:** So, are—was he—what's the phrase you used? COVID—
[00:31:37.04] **ERIN:** COVID rule-out.
[00:31:37.19] **JOHN:** COVID rule-out.
[00:31:38.21] **ERIN:** So, that's how they admit everyone to the floor that doesn't have a positive COVID immediately.
[00:31:45.24] **JOHN:** Okay. So, he's put in the step-down unit, which is a euphemism for "step-up unit." And what happens to him there? What's going on there?
[00:31:56.29] **ERIN:** Oxygen. I wasn't in this unit. My friend was.
[00:32:00.19] **JOHN:** So, just normal oxygen? Nasal—?
[00:32:02.26] **ERIN:** No, they'll do, like, a high pressure—
[00:32:06.14] **JOHN:** So, what does that mean exactly? What does that look like?
[00:32:08.13] **ERIN:** It's pretty much like a forced...it's a big—it almost looks like a big thick nasal canula, and you put it in your nose, and it forces the pressure in. It can almost be like, it's still causing your lungs to expand, right? But what they really need to be doing is the nonrebreather mask, but they just skip it usually. They go right to the high pressure, so their lungs are already, you know—
[00:32:31.15] **JOHN:** So, and just tell us what a nonrebreather mask is.
[00:32:34.24] **ERIN:** So, that's just—there's a bag that is on the end of these masks. It's not forcing air down your lungs.
[00:32:42.09] **JOHN:** Okay.
[00:32:42.09] **ERIN:** It's more natural, you know? And you can put 100 percent oxygen—that's what people need.
[00:32:48.01] **JOHN:** Okay. So, and that, really, is not the protocol? It's not the protocol to start people on that?
[00:32:54.18] **ERIN:** I mean, it should be, but it's not how they're doing it, no.
[00:32:57.18] **JOHN:** I mean, in your prior experience dealing with people with low saturation, would that be what you would do?
[00:33:03.18] **ERIN:** Oh yeah. That's what we were doing, you know, in my hometown.
[00:33:08.24] **JOHN:** And were you having better outcomes there?
[00:33:10.09] **ERIN:** Yeah. We didn't have this. Because we treated them properly, you know?
[00:33:16.14] **JOHN:** What was...what would you say the kind of, the case fatality rate was in your —
[00:33:20.10] **ERIN:** None. Zero. Yeah. By me? Zero.
[00:33:25.07] **JOHN:** And what is the likelihood of coming out of the hospital you're in?
[00:33:30.29] **ERIN:** I'll tell you that the unit that I've been on, the only person that survived, ironically, is a guy who pulled his own tube out.
[00:33:42.09] **JOHN:** So, he woke up enough to be able to do that?
[00:33:43.28] **ERIN:** Yeah. He wanted it out. He should never have been on it in

the first place. That's another, that's a whole other story.
[00:33:50.05] **JOHN:** So, let's just keep going with this 37-year-old. So, he's on the stepdown unit, and he's being given semipressurized oxygen, not a rebreather mask. And then what happens to him?
[00:34:00.29] **ERIN:** They'll start treating them with medications, you know, that will...I-I can't—
[00:34:08.13] **JOHN:** And are they checking his saturation, at this...all the time? Does he have—?
[00:34:12.19] **ERIN:** Yeah. He's on a continuous pulse ox, but, you know, the minute that he desats, like, they'll see, "Oh, no. He's at 87, now." Or, "Oh, look at this. Oh, he's going to need more help." And then they go tell them that they need more help, even if they don't. You know, it-it's ultimately, what it comes down to, is people being just lazy and wanting to treat—they just want to treat, treat, treat, treat, you know? And—
[00:34:37.09] **JOHN:** Is there any incentive to the, okay, you're saying the incentive for the residents is kind of experimental, almost?
[00:34:43.17] **ERIN:** They're order-followers.
[00:34:45.21] **JOHN:** And they're—uh huh.
[00:34:46.21] **ERIN:** You know? Like, they want to please. That's what they're doing—they want to please. And, like, the protocol of that hospital is to treat.
[00:34:57.02] **JOHN:** To treat invasively, according to this protocol. And do we know where this protocol originates? I mean, because obviously, the governor was talking about getting vents. Everyone was talking about getting vents. So, this seems like this comes from very high up.
[00:35:13.27] **ERIN:** Well, yeah. I mean, if you're going to tell somebody, well the entire world, essentially, especially the entire United States, when they're like, "We need the vents!" Like, if you tell people something enough, they're going to start believing it. So, that's exactly what happened.
[00:35:29.17] **VOICE RECORDING:**
[redacted]
NURSE: Tell me why Cuomo immediately thought two months ago that they'd need 30,000 vents? How do you just come up with a number?
[redacted]
NURSE 2: Cuomo's an idiot, too.
[redacted]
NURSE: Someone think Medicaid's paying them more money to—
[redacted]
ERIN: Oh yeah, $29,000 a vent—
[00:35:47.21] **JOHN:** So, our 37-year-old, what happens to him next? So, they say, okay, it looks like he's at 87, he needs more. And so, they, do they, is that the point at which they would intubate him?
[00:35:59.04] **ERIN:** Yeah. That's when he went to the—that’s when he stepped up. So, he stepped up to the ICU.
[00:36:04.23] **JOHN:** He steps up to the ICU—
[00:36:06.11] **ERIN:** For more care, right? They start off with a little bit of muscle relaxer, and, you know, he's woozy. You have to remember, there's no family with these patients, so they're alone, and in a hospital by themselves during a pandemic that they're terrified of already—that’s likely what brought him in in the first place. He's totally healthy, otherwise. Then, you have doctors, they think they're doctors, but they're residents. Technically, they're doctors with absolutely zero experience. I've had to teach residents several nursing skills. Telling them that they have a choice, they could likely die from this, or they can be saved by getting a tube that will help them breathe—they don't

call it a ventilator. "We can give you a little help breathing." And that's it. Then they get the sedation, and they go to sleep, and that's it. They don't wake up. He's in a body bag.
[00:37:10.26] **JOHN:** And, so, the drugs have a deleterious effect on the body, on the brain. But is there something about the pressurization of the lungs that is also causing harm?
[00:37:23.24] **ERIN:** Yeah. They're having the P—that's the pressure in his lungs, which is causing this Barotrauma of—it's blowing peoples' lungs out. So, when that happens, what do you have to do? Turn it up more, you know? You just, you just keep—
[00:37:40.19] **JOHN:** Because the membrane expands, so that it, you need, in order to fill them and deflate them, you need more pressure?
[00:37:47.11] **ERIN:** Yeah. You're going to have to max—I mean, we have a guy right now, who's maxed out on everything. There's nothing more you can do. So, then what? You just wait for them to die? I mean...there's nothing you can do.
[00:38:01.16] **JOHN:** Can you tell us what Peep levels are they started on?
[00:38:05.10] **ERIN:** It depends. They always usually—well, they'll start—there are some good ones—there's—I can't say everybody's bad. There are some good doctors that will start them out on 5, which people should be at a 5. But that doctor goes home, and the next doctor comes on shift and cranks it up. Then what? It's hard to go back down.
[00:38:29.00] **JOHN:** And what oxygen level are they put on?
[00:38:33.03] **ERIN:** It depends. I mean, as they start to deteriorate more and more, then the oxygen obviously is going up. There's a guy right now, I have him on 100% and I'll have to come in and, you know, give him a little bit more rush of 2 minutes of even more oxygen, just to keep his stats up. I mean, that's what happens to people.
[00:38:57.02] **JOHN:** In your home state where you were treating people, what would the protocol be?
[00:39:03.20] **ERIN:** I mean it varied upon each individual, you know? But we definitely would never go immediately to, you know, "You're going to need a vent."
[00:39:20.09] **JOHN:** You didn't feel pressure to diagnose people? There wasn't pressure to diagnose people "COVID?"
[00:39:24.28] **ERIN:** No, not at all, no. We're not a public hospital, too. That makes a huge difference. What I'm seeing is it's the public hospitals, and this is in other states, too, if you look at all the hospitals, most of them are public, that are needing money. But our hospital would just treat them based on the individuals, you know? And they were using the hydroxychloroquine, and the zinc, and you know, that protocol, for sure.
[00:39:54.18] **JOHN:** At your hospital?
[00:39:56.01] **ERIN:** Oh yeah.
[00:39:56.14] **JOHN:** And that seemed to work?
[00:39:57.25] **ERIN:** Yeah. We didn't have anybody that died. I think there was one patient that was admitted and went home, like, the day later. And we're in a, I'm in a pretty big city, so....
[00:40:10.13] **JOHN:** And were these people with, who were elderly, with comorbidities, who were having good outcomes?
[00:40:16.10] **ERIN:** Yeah, actually. The one guy that was admitted came from a nursing home. And he was obese, like, severely obese.
[00:40:26.00] **JOHN:** And he—
[00:40:27.27] **ERIN:** Yeah, he's fine.
[00:40:28.18] **JOHN:** He left after a day?
[00:40:31.02] **ERIN:** I think, well, I think it was like a night, maybe two nights max. But—
[00:40:36.06] **JOHN:** And do you remember what he was treated with?
[00:40:39.19] **ERIN:** I didn't have him on the floor, but I can imagine he was treated with the protocol that we would prescribe the patients before they left the emergency room—
[00:40:49.08] **JOHN:** Which was?
[00:40:50.04] **ERIN:** The hydroxychloroquine, zinc.
[00:40:53.01] **JOHN:** Why do you think that's been demonized so much?

[00:40:56.04] **ERIN:** Because it's working and then people wouldn't need vents. I don't know.
[00:41:01.18] **NEWS ANCHOR:** Only on 2 tonight, a Houston hospital's having success treating the coronavirus patients. In fact, its recovery rate is perfect.

[redacted]

NEWS ANCHOR 2: Fascinating, isn't it?

[redacted]

REPORTER: To treat patients here, Dr. Varon is using an experimental drug protocol. It's a cocktail of vitamins, steroids, and blood thinners. Each patient also is getting hydroxychloroquine, the malaria drug touted by President Trump. The protocol is controversial because there hasn't been time for extensive testing, but Dr. Varon says it works.

[redacted]

DR. JOSEPH VARON: We've treated over 40+ patients with treatment and we haven't had a single complication.

[redacted]

REPORTER: So far, he says, none of his patients have died.

[redacted]

VARON: This is a time of war. It is not time to double-blind anything. This is working, and if it's working, I'm going to keep on doing it.

[redacted]

[00:41:48.26] **ABC7: DR. ANTHONY CARDILLO:** What we're finding clinically with our patients, is that it really only works in conjunction with zinc. So, the hydroxychloroquine opens a zinc channel, zinc goes into the cell, it then blocks the replication of the cellular machinery.

[redacted]

ANCHOR: You're prescribing it, and it is working for COVID 19 patients?

[redacted]

CARDILLO: Every patient I've prescribed it to has been very, very ill, and within 8-12 hours, they were basically symptom free. And so clinically, I am seeing a resolution. That mirrors what we saw in the French study and some of the other studies worldwide. But what I am seeing is that people are taking it alone, by itself, it's not having efficacy.

[redacted]

ANCHOR: Okay.
[00:42:26.12**] JOHN:** What can you tell us about any confirmed COVID cases that you have seen? What, I mean, both in your home state, and here in New York? What have you noticed about them, and what do their stats look like?
[00:42:42.03] **ERIN:** Okay, so the real confirmed COVIDs that come in, you immediately know that they're COVID, because they cannot, like, they can't breathe. They literally can't breathe. So, they do need that nonrebreather mask, or their stats will quickly drop to, you know, 60's, 70's. You want to be at around 90 to 100.
[00:43:05.12] **JOHN:** So, they can't talk, even?
[00:43:07.00] **ERIN:** Some of them can talk. A lot of this is anxiety. But the problem with this is, they were being told, the public has been told to self-quarantine, right? “Stay home.” That's a problem because these people could be getting early, early treatment.
[00:43:24.11] **FOX NEWS:**

[redacted]

DR. MARC SIEGEL: This clinical trial's emerging that appears to show that a decrease of severity early in the game, before you end up hospitalized, before you end up on a ventilator—

[00:43:33.15] **ERIN:** And they're not, because they're told to stay home. So, now they're getting really, really sick. And they come in on an emergency status. They waited too long. if they didn't wait too long, they're easily treatable.

[00:43:45.10] **JOHN:** And easily treatable, you feel, with some of these treatments like zinc and hydroxychloroquine and, you know--

[00:43:55.09] **ERIN:** It's working. I mean, it's been proven to work. There's a doctor, I think, in Texas that's using that protocol and a shot in the butt, you know, of antibiotic shot. I don't know exactly which one she was using, and she's successfully treating. And she was saying that the pharmacist now is calling her every time that she prescribes the hydroxychloroquine and asking what the diagnosis was of the patients, in order to give it to them. I'm like, that's a doctor-patient relationship, so the pharmacist, I guess, was told to do this. And, you know, in New York, the governor pretty much put a ban on it. So, why? Why? What made him, you know, a medical professional now, and make these decisions? And intrude on the doctor-patient relationship? I think I know. You know, I've seen it. They want a vent. He wants to be right. They requested all these vents, they want to use them.

[00:45:02.23] **JOHN:** As part of the same executive order that granted hospitals near-blanket immunity from malpractice litigation during the epidemic, governor Cuomo singled out hydroxychloroquine as the one drug that could not be used as an off-label therapy for COVID-19, except as a part of approved studies. The order was issued, ostensibly, to prevent hoarding, so that those who take this decades-old inexpensive treatment with a long safety record for approved conditions, like lupus, would have access to it. He later amended the order to allow hydroxychloroquine's use in later stage patients and hospitals, but not in early out-patient treatment. Both hydroxychloroquine and chloroquine had shown efficacy in the prior SARS coronavirus epidemic and studies in France and other countries had already shown its effectiveness for COVID-19.

[redacted]

[00:45:56.07] But instead of making research and production of a promising therapy a priority so that there wouldn't be shortages, vents became the near-exclusive focus, along with the search for a vaccine. This has been true, even of President Trump, who, despite his public cheering for hydroxychloroquine, has not made it the focus of warp-speed funding and testing. A number of US studies have shown the promise of hydroxychloroquine-based therapies, most recently a Yale University study focused on early treatment. And in what may be the most scandalous retraction in recent memory, a Lancet paper that purported to show hydroxychloroquine alone or with other therapies was in fact dangerous, has been shown to be based on fraudulent data. Erin's home hospital system confirmed in a phone conversation with Perspectives on the Pandemic that they have used a protocol involving hydroxychloroquine and zinc to great effect.

[00:46:58.14] **JOHN:** Because, in your view, this should be an individually decided doctor-patient choice?

[00:47:03.11] **ERIN:** Everything should be that. I mean, there's no reason that any government should get in between a doctor-patient relationship. That's none of their business. If anything is HIPAA-protected, it should be that. I mean, when you think about it, it's sickening. It's the same reason they won't use other treatments that are successful around the world. And I had a conversation with a doctor about this—

[00:47:29.24] **VOICE RECORDING:**

[redacted]

NURSE: Are you guys doing, like, different sorts of, like, treatments? Because I know, like—

[redacted]
DOCTOR: Nothing works.
[redacted]
NURSE: They have—yeah, but I mean, there's—you know, they're coming out with different things that—
[redacted]
DOCTOR: I know.
[redacted]
NURSE: —are in the testing phase.
[redacted]
DOCTOR: It's the same thing that came with Plaquenil that killed more people than it actually saved, so that's one.
[00:47:47.17] **ERIN:** And he said that they don't work anyway. And I told him, “Well, obviously what you guys have going on here isn't working, so what's the harm in trying?”
[00:47:58.00] **VOICE RECORDING:**
[redacted]
DOCTOR: I don't expect any of these people to survive.
[redacted]
NURSE: Uh huh.
[redacted]
DOCTOR: 90% of them will die.
[redacted]
NURSE: I mean, it's just maintaining, so I figured if it's assumed they're going to die anyway—
[redacted]
ERIN: Just try.
[redacted]
NURSE: Why not throw a few—
[redacted]
DOCTOR: Well, it's--you know? I don't know. That's always an issue in medicine, whether you should explore things, whether they're dying anyway or not. I—
[redacted]
ERIN: But if you could find the cure?
[redacted]
[00:48:19.04] **DOCTOR:** Come on. There's no cure, so there's no antiviral therapy. The only way to do it is a cure, but there's no antiv—
[redacted]
ERIN: A treatment, I should say. Rephrase, "treatment."

[redacted]

DOCTOR: You could treat it, but, you know it's...you have to have some scientific basis for whether these things are working or not, and just throwing everything at them, you could make them worse. So....

[redacted]

NURSE: Worse than death?

[redacted]

DOCTOR: Huh?

[redacted]

NURSE: Worse than death?

[redacted]

DOCTOR: Well, we said 90% maybe that 10% maybe they're able to get through it. I don't know. But I mean, if there's no basis for it working, I mean, you wouldn't just try things just because. I mean...

[redacted]

ERIN: I would.

[redacted]

NURSE: I might, yeah.

[redacted]

ERIN: If it would save my life.

[00:48:56.04] **JOHN:** So, with these actual COVID patients, they present by not really being able to breathe. Maybe they've, as you say, they've probably waited too long. They're not able to breathe, and some of that's anxiety. And what else, so what else do they, how else do they present?

[00:49:14.13] **ERIN:** So, their lungs, if you look at their x-rays, you can immediately see that these patients are effected by COVID because they're white. Their lungs are white. And the secretions are really, really thick mucus-y and white, and that's what the photo—or the x-rays of these lungs look like.

[00:49:37.29] **JOHN:** And so, what does a white lung look mean? Is that just mucus in the lungs?

[00:49:42.19] **ERIN:** Yeah, it's coated. It's almost like their lungs are coated.

[00:49:48.15] **JOHN:** So, that makes it hard to, obviously, transfer oxygen into the blood stream. And so, okay, so they've got very mucus-y lungs, and how do you deal with that? Is that what hydroxychloroquine and zinc do, or—?

[00:50:01.12] **ERIN:** I mean, those treatments are for beginning stages. Like, once you get to the stage where your lungs are looking like that and you're having a lot of trouble breathing, there are proven treatments that have passed three trials in Asia through Dr. Chang, he's a US Board-certified physician, is this extremely high dose IV vitamin C, he's successfully treating people with that. And what that's doing is it's giving your body, essentially your lungs, the power, the antioxidant power, to kick it out, while you can be getting IV antibiotics to be treating this and getting rid of it. But they don't want to have anything to do with it here. What they want to do is just throw them on a vent and sedate them.

[00:50:53.07] **VOICE RECORDING:**

[redacted]
ERIN: Have you done the high dose IV vitamin C that's successful in Asia?
[redacted]
DOCTOR: Oh, that doesn't work. People are trying all kinds of silly stuff. There is no scientific basis for vitamin C to be working here.
[redacted]
ERIN: Well, that Dr. Chang, he was the one that went through the high dose; I'm talking super high dose IV Vitamin c. That's super antioxidants helps your body fight that.
[redacted]
DOCTOR: Yeah.
[redacted]
ERIN: It passed three trials.
[redacted]
DOCTOR: I don't—
[redacted]
ERIN: And it's being effective. It's just weird how everybody just like, shuts it down immediately.
[redacted]
DOCTOR: Nobody tried that because it's, the vitamin C story has been around for a very long time.
[redacted]
ERIN: Oh, that's weird, because I take it daily, and I haven't been sick in—
[redacted]
DOCTOR: Yeah, maybe it's just good genes, that you're not getting sick. I don't think it's from vitamin c. You just have good genes.
[00:51:36.16] **JOHN:** So, how quickly, how quickly does—so, if you have a COVID, and a COVID rule-out, or a non-COVID, right next to each other, on vents, will the COVID patient die more quickly than the non-COVID patient?
[00:51:49.25] **ERIN:** If they're on vents, no. They're both the same, at that point.
Yeah.
[00:51:53.29] **JOHN:** Really?
[00:51:53.26] **ERIN:** Yeah.
[00:51:55.12] **JOHN:** So, even though the COVID patient with the, you know, presenting with a very mucus-y lung—I mean, are their lungs filled, or are they just coated?
[00:52:03.09] **ERIN:** Yeah. I shouldn't say that. I'll take that back. It really depends on the person, how healthy they were before, that really determines how long that they're going to be able to sustain the paralytics and sedation and multiple different procedures. Even when you're sleeping, or you're knocked out, sedated, and they're putting you through these central lines that they're putting in, and traches, they're doing traches, even though—they're practicing, essentially. Your body knows what's going on. It's still going through a trauma. It's very traumatic, even when you're under. That's why a surgery, it takes a while to recover from, because you'll feel it for how long do you feel it if you've ever had a surgery? And so, they're putting their bodies through horrible things and that's adding more stress. it's killing them, yeah.

[redacted]

[00:53:11.03] So, the guy that pulled out his tube is really unique because I saw him from the minute he got to our unit, and I didn't agree with him coming to the ICU. But he was admitted with hyperglycemia, which is high blood glucose, at like 700, so it was pretty high. I learned, later, that it was high because they were treating him with a lot of different psych drugs and that increases—it was the treatment that got him to the 700. And when you have a blood glucose that high, you're automatically going to have altered mental status. So, now, they called him crazy, okay? So, he's admitted to the ICU, and everyone's like, "Well, why is he here?" Because he was acting out, he didn't know where he was. He was confused. And I went in there and he wasn't my patient, but, you know, we help each other, and I went in there and I tried to talk to him and calm him down. I'm like, "Hey," he's just like, "I just want to get out of here, I want to get out of here," and he had soft restraints on, so he's—they restrain everybody. We have soft restraints on all of our patients, the majority of them, for sure. Which is, I think, is crazy. But it goes with the territory, because everybody's really lazy and it's easier to just treat them with drugs or tie them to their beds.

[redacted]

[00:54:33.18] So, he was tied up. Obviously, what is that going to do? It's going to—you're tied up in a hospital, you don't have any family. What do you think you're going to—you're going to freak out. So, he was. And his oxygen was sitting at, you know, 88, you know, 87. The doctor comes in, I should say, fellow comes in, and she says that if he can't get his—she goes, "If you can't get your breathing under control, we're going to have to put a tube in you, to help you with that." And I go, "What?" I'm like, "He doesn't need a tube down his throat. He doesn't need a vent." She goes, "Well, yeah. He's desatting." I said, "No. Absolutely not. He does not need that. We need to get his blood sugar under control and he will be fine, and maybe not tied to this bed." And she goes, "Yeah, we'll talk about it. We'll just monitor him." And this was—I was working night shift; this was probably around 6 am. At...quarter to 7, we had a code down the hall. Did—the code passed, had to do all that. Got out of there. I come back for a shift, and guess what? The guy is on a vent. I was so upset. They did it—I guess the nurses that took over said they did it, literally, as I left.

[00:55:57.06] **VOICE RECORDING:**

[redacted]

ERIN: So, I come back in the morning, and he's on a vent. I'm like, "You have to be fucking kidding me. He did not need a vent."

[redacted]

NURSE 2: They waited for you to leave.

[redacted]

NURSE 3: They did.

[redacted]

NURSE 2: We literally, we literally—that was the morning we coded 28 for three minutes, that we no sooner took the vent out of that room, cleaned it, and put it in here, and tubed him.

[redacted]

NURSE 2: Yeah, they took his vent after he died, and put it on him.

[00:56:18.12] **ERIN:** So, they waited until I left. Because they know how I feel about this stuff.

[00:56:21.18] **VOICE RECORDING:**

[redacted]

ERIN: Same thing with bed 9. They didn't need to intubate him. He was progressing with [...] I don't think that he—

[redacted]

NURSE 2: I don't know what happened after we tried BiPAP and then they brought him here, and I thought, "Well, cross my fingers. We'll see."

[00:56:39.07] **ERIN:** No one survives. He did. He was the only one that I've had.

[00:56:41.05] **VOICE RECORDING:**

[redacted]

NURSE 2: That's what happened with him. He pulled his tube out and so he has a chance again.

[redacted]

ERIN: Oh-oh he did?

[redacted]

NURSE 2: He extubated himself.

[redacted]

ERIN: Oh, he did? I didn't know that. I thought he was extubated.

[00:56:54.14] **JOHN:** And how did he wake up from—?

[00:56:56.05] **ERIN:** Turns out that he did drugs—

[00:57:00.25] **JOHN:** So, he was resistant—

[00:57:02.00] **ERIN:** He was, he—

[00:57:03.10] **JOHN:** To Fentanyl.

[00:57:03.21] **ERIN:** All this stuff that we give normal people didn't cut it for him. So, he ended up, yeah. I'm like, "You just saved your own life, you know?" That's crazy. Don't put that on. Don't put that on. But, I mean, it did. You know what's sad is I pulled it out, and they're like, "Oh, you know, so and so's extubated." I'm like, "No way! They don't extubate anybody. I'm like, that's so weird! And here it turns out that he extubated himself. And now, I mean, he's fine. He's home now. This was just a couple days ago. But, you know, what's sad is that he thinks we saved his life, you know what I mean? So, he's like, "You saved me." And I couldn't. I don't have the heart to be like, "No, man. You saved yourself. You have, like, 9 lives," because had he not have pulled that out, he would definitely, he would definitely be dead. For sure. They don't extubate anyone.

[00:58:04.22] **VOICE RECORDING:**

[redacted]

DOCTOR: Here's the problem.

[redacted]

ERIN: Mmhmm.

[redacted]

DOCTOR: Not a single patient here, since this thing began, has been discharged or successfully extubated.

[00:58:15.00] **ERIN:** I asked the nursing supervisor for a sitter for the guy that pulled his tube out, because when they're waking up, they can be, they can be extra, I should say, where they need a little bit of extra attention. And I asked her for a sitter, and she told me that I didn't utilize all my resources first, which was Haldol, all the psych drugs, to, like, chemically, chemically, you know, put him to bed.

[00:58:42.13] **JOHN:** Your Florida hospital was literally having to furlough people?

[00:58:47.01] **ERIN:** Yes. What was happening is, obviously, they shut down all elective procedures, but they were also waiting for the wave (they called it "the wave"), so we were preparing. And we were in tiers, based on our experience. So, we were tier one, tier two, tier three, tier four. And I was tier one, because I have the, you know, military trauma experience, ICU experience, so on, and so forth. So, I was working, you know, throughout the hospital, training other units. Cross-training. Ultimately, it was to get hours, you know?
[00:59:31.24] **JOHN:** It was what?
[00:59:32.04] **ERIN:** It was to get hours. You know, this is what the hospitals were doing. They're like, "Okay, we're going to give our employees hours this way to cross-train them for when the wave hits." And then that wave would get pushed back another week, and then it'd get pushed back another week, and the units that we were floating to, like cross-training, they're like, "What are you doing here? We don't need you." So, I felt like I was wasting my time and taking up other peoples' time that were trying to get hours too, and this opportunity presented itself, and I took it.
[01:00:09.08] **JOHN:** Do you think that the reason you never got a COVID wave in Florida was because of any of this lockdown or, I mean, what, I mean, I know you're not an epidemiologist, but...what do you think was going on?
[01:00:20.17] **ERIN:** So, I live right by [...] and that was, like, world-wide news. People were at the beach. I was one of those people at the beach with my kids. Sunlight, it's vitamin D, it's good for your immunity. Fresh air, salt water, all these things are really good for anyone's immune system. You have to be out. Mental health, you know. We were all at the beach.
[01:00:45.14] **JOHN:** And so, people, if there was a lot of transmission going on—
[01:00:49.28] **ERIN:** Wouldn't you think our hospitals would be flooded. They were not. I'm right at the beach. I'm right by the beach. Didn't happen.
[01:00:59.28] **JOHN:** Because the lockdowns happened after all that, and—
[01:01:02.25] **ERIN:** It was spring break, you know? The beaches were packed. I mean, there were people from all over the world. They were—people are—tons of New Yorkers live by us.
[01:01:14.03] **JOHN:** What do you—if you—and now I'm asking you to speculate here, because you really feel there is something, a new disease called COVID-19, a new—do you feel that that's the case, or do you think that this is, I mean, I know there is a lot of mislabeling and I know all that, and, but, there really is something new, right?
[01:01:38.02] **ERIN:** Yeah.
[01:01:38.18] **JOHN:** So, okay.
[01:01:39.12] **ERIN:** Yeah.
[01:01:41.11] **JOHN:** Okay. And how, why do you think it, you know, places like New York go—well, okay—we can see that what you were describing at Elmhurst was that they were packing people in together, and so, that would cause spread. but why do you think a place like New York got hit so much harder than other places?
[01:02:04.13] **ERIN:** I thought about that already. What I have found is that, before this happened—because it didn't make sense to me. I'm like, I'm sitting at home, I'm waiting for work. I'm stressing out. A lot of my friends are doing the same. So, I'm like digging. I'm like, why is New York...? Like, what...? Is it because there's that many people crunched in together? But, ultimately what I found is that the hospitals here were already struggling, and I think they shut down multiple hospitals because they couldn't afford to keep them open, so that made sense to me, even though I didn't want it to make sense, you know? Like, there's really no other rhyme or reason because, like—
[01:02:57.07] **JOHN:** But do you think we have, do you think we really do have many more cases regardless of whether or not, you know, people went to the hospital—
[01:03:06.26] **ERIN:** I think they're forced cases. I mean, sure, people are coming in with COVID, whatever that may be. It is something. But not everyone. But they're admitting these people. That's the difference between New York hospitals or these, you know, Michigan. You

know, the states that were, you know, "hit the hardest." They're admitting these patients as possible COVID, calling it “COVID.”
[01:03:40.24] **JOHN:** Or rule-out COVID, or—
[01:03:41.26] **ERIN:** Rule-out COVID. When they maybe just had a little congestion.
[01:03:50.05] **JOHN:** If there was something you would want to tell everyone in the country and everywhere else, one last thing, what would it be?
[01:04:03.12] **ERIN:** I would say this, and this is the one thing that I've had a struggle with: if someone like me or anybody is trying to tell you something that might go against your beliefs, just listen, you know? Like, really, just take it in. And instead of jumping on it, think on it for a night or a day, and look into this stuff. And ask people about it. Like, not every nurse is going to have the same experience. A med-surge nurse that's on a floor, even in my own hospital, has not had the same experience as the ICU nurses have. And once I sit down and explain it to them, it all makes sense. They're like, "Yeah, that makes sense. We see that because we'll send them to your..." You know, so, just, like, just think about it, you know, and be respectful. And like, there—we don't want to—I don't—no one wants to put themselves in a situation like this, you know? And it's really hard. And this is the reason that a lot more people and nurses are afraid because people are so quick to, you know, defend something that they don't really understand.
[01:05:36.08] **JOHN:** What are you referring to, in particular?
[01:05:38.09] **ERIN:** Well--
[01:05:39.29] **JOHN:** Like, this protocol or what?
[01:05:40.11] **ERIN:** Like, I referred to earlier, if you tell people something enough, over and over. Like, the media was telling people, you know, "Vents, vents, vents, vents." And then you say, as a nurse, "No vents." You know, it's not a good position to be in, because I'm going against what the government says. But does the government really have everybody's best interest in mind? You know, are they thinking of, you know, the 57-year-old grandma that didn't have to die, or the 37-year-old that was totally fine when he walked into the emergency room, and he didn't have to die? You know, are they thinking about, you know, maybe the guy that had a drug problem that didn't have to be vented, but he saved his own life? I don't have anything to gain and I have everything to lose by sharing what I'm sharing right now, you know, but so be it, you know? I think it's important that these families get closure, and I hope that someday they'll be able to, you know, hold them accountable for what they did.
[01:07:06.07] **JOHN:** A few days after we recorded this interview, Erin began to feel that her time at Elmhurst was drawing to a close. Her vocal questioning of hospital procedure and her efforts to get the word out on social media were getting noticed. She made this recording on what ended up being her last day at the hospital.
[01:07:27.02] **iPHONE VIDEO:**
[redacted]
ERIN: I've been taking care of a patient for like a week right now, and this is my [...] that I called him. And he's been doing great. He had a trach put in and he's been doing great. He's been talking and, like, communicating with me. He's telling me, like, laughing at my jokes, and talking to his kids on facetime a couple of days ago. And I told him that—I told his kids that he was doing fine. And he was. And today, I was given him, and they came in and they told me that I need to leave the room, and I had to give a report to somebody else, and they took me from that unit and they put me in the emergency room (and they don't need me there, but they put me there), and I'm not even there like 20 minutes, and I'm not even there 20 minutes, and I hear a code being called in my room that I just left. And it's him. And he was fine. He was fine. I don't understand. Nothing makes sense. Why would they take me out of his room, and put me in the ED, and then, not 20 minutes later, he's dead? It doesn't make sense. Like, did they kill him? He was my one patient that was going to live. He shouldn't have died. I don't know what they did to him. Something's not right.

Erin later heard that Ambu-bag ressucitation was improperly performed by a resident, while her patient had a blocked trach.
In response to our query, a spokesman for Medicare/Medicaid said compensation for hospitals varies by state. As of broadcast, NY State has not responded to our inquiry.
The producers have reached out to Elmhurst hospital for comment. Any response we receive will be posted in the description below the video.